IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-554

FRANK S. BEAL, etc., *et al.*,

Petitioners,

v.

ANN DOE, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR RESPONDENTS

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SUMMARY OF ARGUMENT

A. Under Title XIX of the Social Security Act Congress intended that decisions as to what treatment is appropriate for an individual's condition be left to the professional discretion of the physician. The Act requires limitation on or substitution for this discretion by the state be supported by some interest being furthered consistent with the purposes of the Act. Pennsylvania's abortion policy which limits and otherwise disrupts the exercise of physician discretion does not promote any such interest and therefore is unreasonable and violative of Title XIX.

B. By amending Title XIX of the Social Security Act to include Family Planning Services, Congress intended to provide indigent women with a choice as to family size. Congress did not permit states to exclude from Family Planning Services any method which would contravene the purposes of the amendments or exclude a particular class of recipients from benefits. Pennsylvania's limitation on abortion services is violative of Title XIX in that the policy defeats the Congressional objectives and excludes certain women from coverage.

INTRODUCTION

Petitioners, defendants in the district court, are now seeking reversal of the judgment of the United States Court of Appeals for the Third Circuit.[1] The court of appeals held that the regulations and procedures of the Department of Public Welfare of the Commonwealth of Pennsylvania, as such procedures apply to reimburse-

[1] *Doe v. Beal*, 523 F.2d 611 (C.A. 3rd Cir. 1975). Further references in this brief to the lower court opinion are limited to the Appendix.

ment for abortions performed within the first two trimesters of pregnancy, are invalid because they violate Title XIX of the Social Security Act, 42 U.S.C. §1396, *et seq.*[2]

The regulations and procedures of the Commonwealth limited reimbursable abortion services to the following situations:

> "1. There is documented medical evidence that continuance of a pregnancy may threaten the health or life of the mother;[3]
>
> 2. There is documented medical evidence that an infant may be born with incapacitating physical deformity or mental deficiency; or
>
> 3. There is documented medical evidence that a continuance of a pregnancy resulting from a legally established statutory or forcible rape or incest, may constitute a threat to the mental or physical health of a patient;
>
> 4. Two other physicians chosen because of their recognized professional competency have examined the patient and have concurred in writing; and
>
> 5. The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals."

Petitioners contend that this policy distinguishes between abortion services which are medically necessary to protect or maintain the recipients health and those abortion services which are performed for other reasons. Petitioners admit that factors regarding mental health are valid considerations. Brief for Petitioners, note 6, p. 5.

Petitioner's have not acknowledged that the preserva-

[2] Further references in this brief are limited to "Title XIX," "the Act", or the specific United States Code section.

[3] Note that Brief for Petitioners (p. 4) inadvertently omits "or life" in stating the policy. See, App. p. 32a.

tion of a woman's health involves factors recognized in *United States v. Vuitch*, 402 U.S. 62 (1971) and *Doe v. Bolton*, 410 U.S. 179 (1973)[4] including the factor of whether or not the pregnant woman wishes to give birth given her familial status.

To the extent that Petitioners will acknowledge that the breadth of physicians' discretion on the abortion decision is the same under Title XIX as the Court enunciated in the above cases, Respondents concede that the state may legitimately interpose the attending physician between the woman's desire to abort and the services.

Absent this acknowledgement, Respondents submit that Title XIX requires the Commonwealth to pay for all abortion services for eligible women performed by a licensed physician when those services are not contrary to the patient's interests.

ARGUMENT

I.

TITLE XIX STATUTORY FRAMEWORK

A. Generally

Congress in 1965 amended the United States Social Security Act to include Title XIX, Grants to States for Medical Assistance Programs, commonly known as the Medicaid Program. 42 U.S.C. §1396 *et seq.* Title XIX authorizes the yearly appropriation of federal money to enable the states to furnish medical assistance to indigent persons. No state is required to participate in the program.

[4] See the Memorandum for the United States as Amicus Curiae on the Petition for a Writ of Certiorari, note 5, p. 5.

Those states, such as Pennsylvania, which elect to participate with the federal government under Title XIX must develop a state plan to be submitted to and approved by the Secretary of Health, Education and Welfare (H.E.W.). Participating states must conform to federal requirements such as providing for financial participation to share in the cost of the program.

Similarly working programs have been described by this Court as being based on a "scheme of cooperative federalism". *King v. Smith*, 392 U.S. 309, 316 (1968). The state under Title XIX, as opposed to the federal government, is specifically charged with the duty of administering medical assistance.

In revamping the scheme for the use of federal money in providing medical assistance to indigents in 1965, Congress imposed specific limitations on participating states as well as allowing the states certain areas of broad discretion. In understanding how Congress intended responsibilities to be designated certain portions of Title XIX warrant further notation.

For those persons so impoverished as to require financial aid in meeting every day maintenance expenses Congress required that medical assistance be made available. These persons, known as the "categorically needy", are defined as "all individuals receiving aid or assistance under any plan of the state approved under subchapter (Title) I, X, XIV, or XVI, or part A of subchapter IV of this chapter (Act), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter". 42 U.S.C. §1396a(a)(10). 45 C.F.R. §249.10(a)(1).

The scope of medical assistance provided to these "categorically needy" persons must at least include seven basic services as defined in the Act as follows:

> (1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) outpatient hospital services;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

42 U.S.C. §1396a(13)(B) and §1396d(a)(1)-(5).

In addition to the categorically needy, the Social Security Act also allows for the inclusion of persons who are of sufficient means to meet daily maintenance requirements and, therefore, not eligible for cash welfare, but who are otherwise eligible for assistance under the state plan. 42 U.S.C. §1396(a)(10)(C). These persons are known as the "medically needy".

A participating state which includes coverage for the "medically needy" must include within the scope of coverage for these persons at least the seven services listed above as required for the "categorically needy" or the care and services listed in any seven of the clauses numbered (1) through (16) of section 1396d(a). 42 U.S.C. §1396a(a)(13)(C).

Congressional authorization for the appropriation of federal money under Title XIX is accompanied by a broad, two-pronged statement of purpose. On one hand the authorization is to enable the states to provide medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services. In addition, the authorization is for the purpose of enabling the states to provide services to help such indigent families and individuals to attain or retain capability for independence or self-care. 42 U.S.C. §1396.

The broad statement of purposes has generally remained consistent since the passage of the Act in 1965. The original Act, however, included a more specific Congressional goal of broadening the scope of medical and remedial services until a comprehensive program was achieved by a date certain:

> "(e) The Secretary shall not make payments under the preceding provisions of this section to any state unless the state makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care." 42 U.S.C. §1396b(e) (repealed 1972).

This specific language was repealed by the 1972 amendments to the Social Security Act. Recent legislative history reveals, however, that Congress has

not totally abandoned its original goal of comprehensive services.[5]

Also noteworthy is that Title XIX does not contemplate that states directly provide medical services to the beneficiaries of the program. Rather the Act envisions a system of state reimbursement to health care providers when services are rendered to eligible individuals. 42 U.S.C. §1396d(a). This system allows the beneficiary to select the provider of services to the extent the program can attract providers to participate. 42 U.S.C. §1396a(a)(23). No provider of services is required to participate in the program and, therefore, no beneficiary is guaranteed services.

B. State Discretion

The scheme of cooperative federalism as operative for the furnishing of medical assistance to indigents gives the states wide latitude in tailoring the medical assistance program to meet the needs and conditions existing in the particular state. 42 U.S.C. §1396.

No state is required to participate in the federal program. Each state can elect whether the "medically needy" will be included as beneficiaries. A state electing to include the "medically needy" is given a range of options as to the scope of services to be made available to them. Each of these examples of state discretion indicates the Congressional recognition that varying factors, such as economic factors, within each state require differing approaches to providing medical assistance.

In addition to these more clearly defined state

[5] See comment, Abortion on Demand in a Post-*Wade* Context: Must the state pay the bills?, 41 Fordham Law Review 921, 932 (1973). See also *Doe v. Beal*, n. 14 (A. 142a).

options, Title XIX also indicates that the states will have wide discretion in determining the extent of services to be provided. Repeated references in the Act to amount, duration and scope of medical assistance imply the state's role in defining extent of services.[6]

Limitations

While Title XIX does not explicitly define the parameters of state discretion in determining the extent of assistance, it is clear, especially in light of the following, that unbridled state discretion in this area was not envisioned.

The Act imposes limitations on state discretion by the "comparability standard" which requires that the medical assistance made available to the medically needy not be less than that available to the categorically needy. And in addition, assistance available to individuals within each category must be equal to assistance available to other individuals within the same category. Section 1396a(a)(10) which reads in part as follows:

> (10) provide–
>
> (A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the state approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI or this chapter;
>
> (B) that the medical assistance made available to any individual described in clause (A)–
>
> (i) shall not be less in amount, duration, or

[6] See the lower court's discussion of the areas of state discretion. (A. 135a-137a).

scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause A; and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate state plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary–

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such state plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope.

To the extent which the Act permits the states to limit assistance it requires the states to adopt standards in defining the extent of medical assistance. The Act further requires that such standards be reasonable and consistent with the objectives of Title XIX. 42 U.S.C. §1396a(a)(17).

Regulations issued by H.E.W. pursuant to the Act further indicate the limitations on state discretion in extending services. Each state plan must:

Specify the amount and/or duration of each item of medical and remedial care and services that will be provided to the categorically needy and to the medically needy, if the plan includes this latter

group. Such items must be sufficient in amount, duration and scope to reasonably achieve their purpose. 45 C.F.R. §249.10(a)(5).

One court has held that this regulation prevents a state medical assistance plan from limiting the providing of eyeglasses to persons with eye pathology as opposed to ordinary refractive errors. *White v. Beal*, 413 F. Supp. 1141 (E.D. Pa. 1976), appeal pending.

The district court in *White* found that the purpose of eyeglasses is to aid or improve vision and that refractive errors constitute more of a visual impairment than eye pathology. Thus, the court held that such a limitation was impermissible since the limited service was not sufficient to reasonably achieve the purpose.

An additional part of the same regulation [45 C.F.R. §249.10(a)(5)] further limits states' discretion by prohibiting them from arbitrarily denying or reducing the amount, duration or scope of services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition. This standard was additionally relied upon in *White*, *supra* in holding the eyeglasses limitation invalid.

The prohibition against limiting assistance based on a diagnosis, type of illness or condition has been relied upon by H.E.W. in formulating a policy concerning state attempts to eliminate particular treatments. In Policy Information Memo No. 3 from the Medical Services Administration to regional staff, which memo is dated August 27, 1970, the following language appears:

"4. We believe that if the provision in Handbook Supplement D-5140, stating that 'limitations may not be set by eliminating certain groups of patients or certain diagnoses from coverage,' is retained, the state is equally precluded from eliminating any particular treatment from its program. For example, if a patient receives hemodialysis as part of

> his inpatient hospital care, this particular treatment method presumably would have to be paid for. That this treatment is expensive is not a reason for precluding it under Medicaid. On the other hand, as far as expensive practitioners' services are concerned, such as psychoanalysis, the states have some control by virtue of their authority to establish maximum fee schedules."

The Handbook provision to which reference is made is now contained in its essence in H.E.W. regulations, 45 C.F.R. §249.10(a)(5).

Further limitation on state discretion can be found in the federal definitions of medical services. The statutory listing of services [42 U.S.C. §1396d(a)(1)-(17)] provides no explicit indications that a state is limited in defining the extent of any particular service. Federal regulations, however, define the listed services. 45 C.F.R. §249.10(b). This regulation can be read as mandating the inclusion of care and services in state plans to the extent such services are defined in the regulations.[7] Given the breadth of some of the definitions, however, it is unlikely that they were intended to be mandatory.[8]

Despite the inability to interpret Congress's listing of services as a general mandate on the states in defining the extent of services, certain services listed in the Act are so narrow as to their goal that such goal cannot be reasonably achieved without mandatory inclusion of certain specific methods. For example, early and periodic screening and diagnosis of children [42 U.S.C. §1396d(a)(4)(B)], given acceptable professional

[7]The introductory phrase in the regulation reads in part as follows: . . . "Federal financial participation is available in expenditures for medical or remedial care and services under the state plan which meet the following definitions:"

[8]See the lower court's discussion of this point. (A. 144a-147a).

standards for an adequate screen, could not be said to be more than mere tokenism if a visual examination were not included in the screen. Notwithstanding the lack of a specific statutory reference to eye examinations, Congressional intent to include such service is manifest reading the Act as a whole. H.E.W. regulations making this service mandatory on the states support this conclusion. 45 C.F.R. §249.10(a)(3)(IV).

These examples are illustrative of the notion that unbridled state discretion as to the extent of medical assistance is not contemplated by Title XIX. Respondents submit in their final argument that Pennsylvania is specifically prohibited from reimbursing only select abortion services based on the 1972 amendments to the Act concerning family planning services. In addition, Respondents first argue that approaching Title XIX with regards to the division of responsibility between the state and physician as contemplated by Congress renders Pennsylvania's limitations impermissible under the Act.

C. Physicians' Discretion

While the 1965 Congressional attempts at establishing a comprehensive national health program were bound to have a significant impact on the delivery of health services in our country, nothing in the statutory framework indicates that Congress intended to disrupt the traditional roles which each party, necessary to the delivery of such services, had previously fulfilled.

The federal government would provide substantial amounts of money to the states and set parameters within which the states must function; each participating state would share in the cost of the program, administer the program within the state and tailor the program to meet the particular needs and conditions

within the state;[9] doctors and other providers of services would continue to exercise their professional judgments in the best interests of patients; and recipients or patients would retain a free choice of providers of services as is fundamental in the private sector.

Specific provisions of Title XIX taken collectively reflect Congressional intent that physicians participating in the program are to retain their traditional function of determining what treatment and services are most appropriate for individual patients. The Act requires each participating state to provide such safeguards as may be necessary to assure that care and services will be provided in a manner consistent with simplicity of administration and the best interests of recipients. 42 U.S.C. §1396a(a)(19). The simplicity requirement is contrary to the administrative burden of individualized state determinations on what treatment is appropriate for individual patients. Further, the best interests of recipients cannot be served unless the difficult task of selecting treatment appropriate for a condition requiring medical attention is primarily retained within the province of the physician.

The statutory requirement that recipients be given a free choice of providers of services [42 U.S.C. §1396a(a)(23)] becomes a hollow grant to the extent state imposed standards in the election of treatment are tolerated within the program.

In concluding that Congress intended the physician to retain primary authority in deciding what treatment

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[9]Compare the states' role in the Medical Assistance Program with its role under Title IV of the Social Security Act, Aid to Families with Dependent Children, 42 U.S.C. §601 *et seq.*, *King v. Smith*, 392 U.S. 309 (1968); *Townsend v. Swank*, 404 U.S. 282 (1971); *Carleson v. Remillard*, 406 U.S. 598 (1972); *Burns v. Alcala*, 420 U.S. 575 (1975).

is appropriate for a recipient under both Titles XVIII and XIX, the Court of Appeals (A. 141a) properly relied on the Report of the Senate Committee on Finance, reporting favorably on the amendments:

> (1) Physicians' Role
>
> The committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments and determine the length of stay. 1965 U.S. Code Cong. & Adm. News 1943, 1986.

It is noteworthy that as part of Title XVIII of the Act, Health Insurance for the Aged and Disabled (Medicare), Congress specifically included a prohibition against Federal interference:

> Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.... 42 U.S.C. §1395.

In regards to this prohibition, see also in the legislative history 1965 U.S. Code Cong. & Adm. News p. 1965:

> The responsibility for, and the control of, the care of the beneficiaries rests with the hospitals, extended care facilities, the beneficiaries' physicians, etc.

Congressional intent to preserve the role of the physician within the Title XIX scheme has been recognized by federal courts in addition to the Third Circuit. The district court in *Roe v. Ferguson*, 389 F. Supp. 387, 392 (S.D. Ohio 1974) rev'd and rem. 515 F.2d 279 (C.A. 6th Cir. 1975) spoke of the "protection which the Social Security Act normally affords the physician-patient relationship." Also, the district court in *Roe v. Norton*, 380 F. Supp. 726, 729 (D. Conn.

1974) rev'd and rem. 522 F.2d 928 (C.A. 2nd Cir. 1975) perceived the basic philosophy of Title XIX as emphasizing wide discretion in the physician as to treatment decisions.

Finally, it is especially important that Petitioners are in accord with the special emphasis placed by Congress on the role of physician in the Title XIX scheme:

> Petitioners agree that an overriding concern of Congress in Title XIX was that states not interfere with the exercise of a physician's discretion. But certainly that discretion is not boundless. Brief for Petitioners, p. 18.

II.

PENNSYLVANIA REGULATIONS WHICH LIMIT ALTERNATIVE TREATMENTS FOR PREGNANCY FURTHER NO STATE INTEREST AND, THEREFORE, ARE VIOLATIVE OF TITLE XIX.

As demonstrated above, Title XIX does not support the notion of either absolute state discretion or absolute physicians' discretion. Rather, when conflict arises between the functions of the doctor and state, the Act contemplates a rational analysis which will result in the best interests of recipients being served. 42 U.S.C. §1396a(a)(19). Pennsylvania's limitations on abortion services except in narrowly defined circumstances eliminate a particular alternative treatment for pregnancy without any rational basis and, therefore, as argued below, are not consistent with the Act.

Given the complexity and ever-changing nature of the matter addressed by Congress in Title XIX, it cannot be expected that specific language on every possible service would appear in the Act. Despite the lack of a specific reference to abortion services in the Act and despite the

sensitive nature of the issue,[10] whether a state may eliminate this treatment from the medical assistance plan should be answered by reference to the general statutory standards for permissible state intervention into the realm of physicians' discretion.

Any state limitation in the extent of medical services is subject to the federal standard contained in 42 U.S.C. §1396a(a)(17) which requires a rational basis for the limitation and that it be consistent with the purposes of the Act. Given the Congressional emphasis on physicians' discretion, state limitations on alternative treatments appear subject to a more strict standard of rationality than general limitations on broad medical conditions. Assuming that the treatment selected by the physician is within the legitimate practice of medicine as defined by state law [42 U.S.C. §1396d(a)(5)], the state should be required to demonstrate textually how a statutorily permissible purpose is being furthered by the interference with the physician's choice.[11]

This approach to Title XIX as applied to abortion services renders Pennsylvania's limitations on those services impermissible.

This Court has already recognized in the criminal context that a physician treating a pregnant woman may exercise his professional judgment free of state

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[10] See *Roe v. Wade*, 410 U.S. 113, 116 (1973).

[11] Analytically, this position is similar to the judicial treatment of eligibility under Title IV of the Act, Aid to Families with Dependent Children. If a category of individuals is included in the federal standard a state may not eliminate the category unless federal authorization for the option is manifest. *Burns v. Alcala*, 420 U.S. 575 (1975), *King v. Smith*, 392 U.S. 309 (1968). Here, the federal standard for inclusion, while not as specific as in Title IV, is founded on the Congressional emphasis on physicians' discretion. Limitations on that discretion must satisfy the federal requirement [42 U.S.C. §1396a(a)(17)] of a rational connection to a statutorily permissible interest.

intervention up to the point where compelling state justification exists. And further that, "up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician." *Roe v. Wade*, 410 U.S. 113 (1973).

Thus, the lower court's conclusion (A. 149a) that pregnancy is a condition for which treatment is necessary and that the appropriate treatment is to be determined by the attending physician is consistent with this Court's views as well as other federal courts. See *Roe v. Norton, supra; Klein v. Nassau County Medical Center*, 347 F. Supp. 496, 500 (E.D.N.Y. 1972) vac. and rem. 412 U.S.C. 925 (1973).

Since Pennsylvania's policy limits the availability of an alternative treatment for a condition otherwise covered by the program, it works a disruption on the physician's choice and, thus, is subject to closer scrutiny than broad exclusions.

Concern for limited financial resources and concern for the health and safety of recipients are possible statutorily permissible interests which might be furthered through certain limitations on the extent of medical services provided by a state. When these interests are offered as justification for limiting physicians' discretion, however, several points must be noted. Other mechanism, such as the setting of fee schedules,[12] are available to the state to accommodate financial concerns. Also, to the extent the state is acting out of concern for the recipient, it must be remembered that Congress intended the physician to be the primary guardian of the recipient's health and safety.

Any state limitation on reimbursement for abortion

[12]See, *District of Columbia Podiatry Society v. The District of Columbia*, 407 F. Supp. 1259 (D.D.C. 1975).

services cannot be justified as furthering an economic interest. Abortion generally will be the least expensive of the alternative treatments attendant to pregnancy. *Doe v. Beal* (A. 149a); *Doe v. Rose*, 499 F.2d 1112, 1117 (C.A. 10th Cir. 1974); and *Klein v. Nassau County Medical Center*, 347 F. Supp. 496, 501 (E.D.N.Y. 1972) vac. and rem. 412 U.S. 925 (1973). Thus, only the most unrestrictive abortion policy can further the state's interest in achieving the most economical distribution of limited Medicaid resources.

Likewise, restricted abortion services cannot be justified under the Act as furthering the state's concern for the health and safety of beneficiaries. Abortions performed earlier in pregnancy constitute a significantly reduced risk to the patient's health than later treatments. *Beal v. Doe*, (A. 149a, 150a); Affidavit of Douglass Thompson, (A. 36a); and *Roe v. Wade*, 410 U.S. 113, 150 163 (1973).

Respondents respectfully submit, as was concluded by the lower court (A. 149a), that no justification consistent with the Act can be found for limiting the physician in selecting abortion as appropriate treatment for pregnancy.

Absent some textually demonstrable interest being furthered, the state standards for defining which abortions will be reimbursed cannot be said to be "reasonable" as required by Title XIX. As the Court of Appeals concluded (A. 149a), absent some state interest being furthered a limitation constitutes "[g]ratuitous interference with medical decisions by doctors" and this cannot be consistent with the purposes of Title XIX.

Medical Necessity

Title XIX contemplates that the exercise of state discretion in defining the extent of medical assistance

will include consideration of medical necessity. 42 U.S.C. §§1396, 1396a(a)(30); 45 C.F.R. §249.10(a)(5)(a).[13] As discussed below, however, state concern for the necessity of a particular medical service is appropriate when a particular condition is diagnosed and is not properly asserted by the state at the time the choice of treatment must be made. This important distinction allows both the state and the physician a sufficient range of discretion to assure that the best interests of the recipients will be served as Congress intended.

A state program which limits medical assistance services to those which are medically necessary would appear to be striving to distribute limited financial resources in response to the most urgent needs of beneficiaries and, thus, in the best interests of recipients. To the extent that the state's concern for limited financial resources is inherent in decisions based on medical necessity some demonstrable interest is being furthered. However, Respondents submit that medical necessity in a vacuum, that is where no statutorily permissible interest is being furthered, cannot justify consistently with Title XIX state interference with the doctor's exercise of sound professional judgment. To assure that state reliance on considerations of medical necessity further some interest, these considerations will generally be limited to the broad decisions on whether certain conditions on diagnosis will be covered by the program. Once the condition is deemed by the state as requiring medical attention, the individualized determination of the appropriate treatment is a professional judgment involving necessity that the physician is called upon to

[13]Congress did not define medically necessary as it appears in 42 U.S.C. §1396, nor was its use in section 1396(a)(30) which was adopted in 1967 accompanied by a definition.

make routinely. See *Doe v. Bolton*, 410 U.S. 179, 1972 (1973).

Given limited financial resources for medical assistance a state may, for example, wish to exclude routine physical examinations from coverage under its medical assistance program. The issue of whether such examinations are "medically necessary" may draw varying opinions within the medical community. Despite the probability that certain recipients will suffer by not having disorders or impairments discovered sufficiently early, a state could chose not to provide such service based on considerations of necessity.[14] This statutorily permissible exercise of state discretion based on medical necessity does not, however, involve limitations on physicians' discretion in selecting treatment for a condition otherwise requiring medical attention. Also a state's decision not to provide routine physic examinations is not based on medical necessity in a vacuum, but rather furthers the state's legitimate concern of addressing recipients' most urgent needs with limited resources.

Exercise of state discretion permissibly based on medical necessity at the time a condition is diagnosed must be contrasted with attempts to exclude a particular medical treatment from coverage based solely on the fact that other treatments applied later will either restore or preserve the patient's health. A state could not, for example, consistently with Title XIX exclude the use of cobalt as a treatment for cancer and thereby limit the alternative treatments to surgery. Nor as the lower court (A. 143a) suggested by way of example, could a state exclude early treatment for a tooth cavity thereby limiting treatment to extraction after the tooth has abscessed. Unless the state is

[14]This choice is not available to the states regarding children. 42 U.S.C. §1396d(a)(4)(B).

furthering some interest, such as requiring treatment to be consistent with established medical procedures in the interest of the recipient, the existence of alternative procedures cannot render one treatment unnecessary consistent with Congressional intent under Title XIX.

This analysis of medical necessity under Title XIX assures that the broad purposes of the Act will not be frustrated. The state is provided sufficient breadth of discretion to protect their own interests without undue interference with the physicians' discretion. The best interests of the recipients, both individually and collectively, will be advanced to the greatest extent possible. 42 U.S.C. §1396a(a)(19). And states will be held to the requirement that exclusions be rationally based furthering some demonstrable interest. 42 U.S.C. §1396a(a)(17).

In applying this analysis to the abortion decision it become apparent that state reliance on notions of medical necessity do not properly support limitations on abortion services.

In addition to the Court of Appeals, other courts have recognized that as to pregnancy, whether a particular treatment is necessary or unnecessary cannot constitute state justification for limiting physician discretion. The district court in *Roe v. Norton, supra* at 729 stated as follows:

> There is nothing in the text or legislative history of the statute to suggest that when a patient's condition requires medical attention each alternative form of medical service that might be rendered must be deemed to be necessary to qualify for federal reimbursement. Such a notion would be contrary to the basic philosophy of both the Medicare and Medicaid provisions, which emphasizes the wide discretion to be accorded physicians in treating their patients . . . [W]hen a patient's condition does require some medical attention, the choice of service to be rendered

> should normally be a matter between doctor and patient, and the service they select is eligible for payment, so long as it is an accepted medical procedure, and does not involve costs that are excessive compared to adequate alternatives. *Roe v. Norton, supra,* 380 F. Supp. at 729.

The court in *Coe v. Hooker,* 406 F. Supp. 1972 (D.N.H. 1976) (appeal pending) recognized that while the *Norton* decision was reversed by the Second Circuit, this particular point was affirmed:

> Pregnancy is plainly a physical condition which requires medical attention. The nature of the services to be rendered is a matter between patient and doctor. If the woman carries the pregnancy to term, such services will normally include prenatal care, obstetrical services and post partum care. If, on the other hand, the woman elects to terminate her pregnancy by having an abortion permitted by law (in the first trimester, or otherwise), the medical services required are those in performing the abortion and an appropriate care thereafter. The care and services rendered in either of these circumstances would be equally "necessary" if such a showing were required by Title XIX. *Roe v. Norton, supra* at 934.

See also *Klein v. Nassau County Medical Center,* 347 F. Supp. 496, 500 (E.D.N.Y. 1972) vac. and rem. 412 U.S. 925 (1973).

In the context of criminal law, this Court in *Doe v. Bolton,* 410 U.S. 179, 191 (1973) has indicated, concerning the abortion decision, that even after a physician has exercised his best clinical judgment in light of all the attendant circumstances, it is still constitutionally permissible to require that the abortion be "necessary". This position the Court made clear was to assure that the judgment operated for the benefit, not the disadvantage, of the pregnant woman. The only abortion services remaining to fit the category of

"unnecessary" would be those contrary to the patient's interests.

Given the *Doe v. Bolton* analysis, the state has a legitimate interest in assuring that the physician's judgment on abortion, as in any context, will operate to serve the individual's best interests. Thus, abortion services performed without the informed consent of the patient or where pregnancy is not in fact established need not be reimbursed by the state. A state need not under XIX reimburse for abortion services which otherwise in the state have been declared illegal.

III.

PENNSYLVANIA'S LIMITATIONS ON ABORTION SERVICES VIOLATE THE TITLE XIX REQUIREMENT THAT EACH STATE PROVIDE COMPREHENSIVE FAMILY PLANNING SERVICES.

In 1972, Congress amended Title XIX[15] adding as a required medical assistance service,

> Family Planning Services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies. 42 U.S.C. §1396d(a)(4)(C).

Congress initiated mandatory programs of Family Planning Services for the purpose of providing low-income individuals and families with, "The freedom of choice to determine the spacing of their children and

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[15]*See* Act of Oct. 20, 1972, Pub. L. 92-603, §299E(b), 86 Stat. 1459-1462.

the size of their families".[16] By enabling indigent persons to limit the size of their families and/or space their children, Congress sought to assist, "those families . . . who desire to control family size in order to enhance their capacity and ability to seek employment and better meet family needs." Sen. Rep. 92-1230, supra. 297.[17]

Family Planning Services illustrate that certain mandatory "medical assistance" services are to be provided by the states for reasons other than to primarily promote physical health. It is the goal of limiting and/or spacing of children which a state's family planning program must foster to the maximum extent possible given the conditions in such state.

Prior to 1972, Congress sought to provide indigent persons with the opportunity to space their children and/or limit family size by requiring each state participating in the AFDC program to offer and provide family planning services to any AFDC recipient who requested such services.[18]

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[16]*See* 113 Cong. Rec. 23085 (8/17/67); Sen. Rep. No. 92-1230, 92nd Cong., 2nd Sess. 297 (1971).

[17]*See also* 42 U.S.C. §1396 and 42 U.S.C. §602(a)(15), which set forth as one of the broad goals of Federal assistance programs generally, the improvement of indigent persons' ability to attain and/or retain capacity for independence or self-care.

[18]*See* Act of Jan. 2, 1968, Pub. L. 90-248, §201(a)(1)(C), 81 Stat. 877 (42 U.S.C. §602(a)(15), which provided: (A) for the development of a program for each appropriate relative and dependent child receiving aid under the plan, and each appropriate individual (living in the same home as a relative and child receiving such aid) whose needs are taken into account in making the determination under clause (7), with the objective of–

> "(i) assuring, to the maximum extent possible, that such

(continued)

Despite Congressional intention that the 1967 family planning amendments would assure the availability of comprehensive family planning services, the states failed to provide such services in the manner intended. In practice, the majority of states provided few "services" or "supplies," providing instead, mostly counseling and referral.[19]

(footnote continued from preceding page)

relative, child, and individual will enter the labor force and accept employment so that they will become self-sufficient, and

"(ii) preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life,

"(B) for the implementation of such programs by–

"(i) assuring that such relative, child, or individual who is referred to the Secretary of Labor pursuant to clause (19) is furnished child-care services and that in all appropriate cases family planning services are offered them, and

"(ii) in appropriate cases, providing aid to families with dependent children in the form of payments of the types described in section 406(b)(2), and

"(C) that the acceptance by such child, relative, or individual of family planning services provided under the plan shall be voluntary on the part of such child, relative, or individual and shall not be a prerequisite to eligibility for or the receipt of any other service or aid under the plan,

"(D) for such review of each such program as may be necessary (as frequently as may be necessary, but at least once a year) to insure that it is being effectively implemented,

"(E) for furnishing the Secretary with such reports as he may specify showing the results of such programs, and

"(F) to the extent that such programs under this clause or clause (14) are developed and implemented by services furnished by the staff of the state agency or the local agency administering the state plan in each of the political subdivisions of the state, for the establishment of a single organizational unit in such state or local agency, as the case may be, responsible for the furnishing of such services."

[19]*See* Rosloff, *Family Planning Provisions of the Social Security Amendments of 1972* (HR-1), Oct. 20, 1972; and

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The 1972 amendment to Title XIX was a Senate response to concern that the then existing family planning programs were not successfully providing recipients with the ability to plan their parenthood and that as a consequence, economic improvement as well as family life were not being significantly enhanced. Recognizing that the aims of family planning were not being met, in large part because the states were not providing recipients with coverage for the medical services aspects of family planning, Congress sought to emphasize that such services are "primarily medical services".[20] By increasing the percentage of Federal cost participation to 90%[21] and requiring states to provide, for the first time, family planning services as a medical assistance service, Congress sought to finally assure indigent persons that comprehensive family planning services would be available to enable them to choose when and if to have children.

Thus, contrary to the Petitioner's assertion at page 18 of his brief that physicians are not to be viewed as experts in recommending "services–even medical services," which assist in primarily fostering a social or economic goal, the 1972 Title XIX amendments to §1396d illustrate that Congress considered the physician to be the primary provider of family planning services, a medical service which Congress did not provide primarily to promote physical health but to instead improve indigents' ability to seek and hold employment and better meet family needs.[22]

(footnote continued from preceding page)

Charles, *Enforcing Legal Rights to Family Planning and Abortion*, 8 Clearinghouse Review 422 (Feb. 1971) and authorities cited therein.

[20]*See* Sen. Rep. 92-1230, *supra.*, 295-298.

[21]42 U.S.C. §1396b(a)(15).

[22]This failure of the appellant to recognize that Title XIX

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By amending Title XIX Congress intended to provide recipients with *comprehensive* family planning services and, without doubt, any program of "comprehensive family planning" is generally viewed by medical experts and public health officials as encompassing such specific medical techniques as contraception, abortion, sterilization and treatment for infertility.[23] Abortion is generally recognized as a necessary element in a comprehensive system of family planning because it serves as a "back-up method" of handling contraceptive failure and as a means of meeting family planning needs where cont ptives have not been used or provided.[24]

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"Medical Assistance" services were made available for purposes other than improving physical health has also led him into another false assumption that the sole touchstone of medicaid programs is "medical necessity". As is discussed *infra*, the scope of required family planning services are not to be defined by the extent to which the inclusion of a given method is "medically necessary". Instead, the scope of such services is to be defined in part, by the extent to which the exclusion of a given method would be inconsistent with the statute's general requirements and would lessen the successful attainment of the Congressional purpose; in the case of family planning services, the chance to limit family size and thus foster the economic and social goals of family planning. This assumption is further weakened by the fact that the state does provide coverage for *sterilization* as a family planning service even when it is only to further a goal unrelated to physical health. *See*, affidavit of Henry J. Smith (A. 42a).

[23]Wallace, Goldstein, Gold and Oglesby, *A Study of Title XIX Coverage of Abortion*,- Am. J. Pub. Health, 1116-1120 (Aug. 1972).

[24]*Report of the President's Commission on Population Growth and the American Future*, G.P.O., 1972, 103; *See also Report of Secretary of H.E.W. submitting 5 Year Plan for Family Planning*, prepared for Special Subcomm. on Human Resources of the Sen. Comm. on Labor and Pub. Welfare, 92 Cong. 1st Sess. (Comm. Print 1971) at 319 (Hereinafter, Report of Secretary), where H.E.W. indicated that abortions were an element of compre-

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Many health experts consider the most rational and successful system of family planning to be one which prevents fertility by use of a contraceptive which is medically safe for use by the particular patient and which is backed up by the early aborting of pregnancies resulting from contraceptive failure.[25]

At present, every known method of family planning has serious shortcomings.[26] Because family planning requires a selection from a number of imperfect alternatives, a workable comprehensive program requires judgments to be made in each individual case by a doctor and patient, on the basis of each patient's physical and emotional condition as well as their consciences. Like any Title XIX "medical assistance" service, a particular method of family planning services is not available upon a patient's "demand". The choice of method is not the patients' unilateral decision but is a joint decision made by the patients and their physicians. *Doe v. Bolton, supra.* An abortion is but one method of family planning the availability of which

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hensive family planning services; and C. Luker, *Taking Chances: Abortion and the Decision Not to Contracept* (1975) 20.

[25]C. Tietze, "Induced Abortion–A Factbook", Reports on Population/Family Planning 48 (1972).

[26]Oral contraceptives while highly effective and reliable often produce adverse side affects with or without prolonged use, and are therefore not medically acceptable method for many women. *See Contraceptive Technology*, Emory University School of Medicine, 1972, and sources cited therein; the intrauterine coil (I.U.D.) is not entirely effective and many women's bodies reject it. C. Tietze, *Manual of Family Planning and Contraceptive Practice* (Mary Calderone, Ed.) 2nd Ed., 1970, 269-71; Similarly, the diaphram and the condom are ineffective in many instances. C. Tietze, *ibid;* Contraceptive foam also has a significant failure rate, G.S. Bernstein, "Clinical effectiveness of an Aerosol Foam", 3 Contraception 37, 43; the rhythm method has obvious shortcomings.

enlarges the freedom of physicians and patients to select a safe foolproof scheme to space and/or limit childbirth. The knowledge that an abortion is available as a back-up service thus permits a physician to prescribe, for those women whose history's caution against a particular form of contraception, a less effective but more medically appropriate form of contraceptive.[27]

The Congressional decision to use the general phrase "family planning" to secure the mandatory provision of comprehensive family planning program in 42 U.S.C. §1396d(a)(4)(C) given the commonly defined scope of that phrase strongly indicates an intention to require coverage of abortions as part of the mandatory comprehensive family planning services each state must provide.

The failure of Congress to expressly exclude abortions as a covered method of family planning under Title XIX when it had done so previously[28] is additional evidence of an intention to include abortions as a covered item of family planning under Title XIX. "A change in phraseology creates a presumption of a change in intent, and that Congress would not have used different language . . . without intending a change in meaning." *Crawford v. Burke*, 195 U.S. 176, 190 (1904); *Brewster v. Gage*, 280 U.S. 327, 337 (1929); *United States v. Dickerson*, 310 U.S. 554, 451 (1940).

Of additional significance is the fact that Congress was aware in 1972 that H.E.W. considered abortions to be a part of then existing comprehensive family

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[27]To the extent the inclusion of abortion services permits physicians and their patients wider discretion in adopting safe, successful family planning programs such inclusion certainly serves the best interests of recipients. 42 U.S.C. §1396a(a)(17).

[28]*See* 42 U.S.C. §300a-6, where Congress excluded coverage of abortions as a method of family planning.

planning service programs. *Allen v. Grand Central Aircraft Co.*, 347 U.S. 533, 544 n.12 (1954). In, "Report of the Secretary", H.E.W. indicated, under the heading, *Family Planning Delivery System as it Now Exists*, that:

> "Within the context of Family Planning Service Programs, abortions are . . . viewed . . . as a service that should be available in accordance with local laws only in the event of a human or contraceptive failure." *supra*, at 319.

Also, in Hearings on H.R. 4208 before the House Sub-Committee on Public Health and Environment, 91st Cong., 2nd Sess. 1971, Part I, former Secretary of H.E.W., Elliott Richardson in response to an inquiry from Congressman James Hastings discussed the agency's view of abortions and family planning:

> *Mr. Hastings:* "Along those lines, and a controversial question, and particularly in light of the action of several states recently, and talking about unwanted children, do you anticipate a policy emanating from your department as it relates to legalized abortion?
> *Secretary Richardson:* I don't anticipate that we would take a position on this as a Federal agency beyond saying in effect, that one, this is a matter for state action, and two, that in general we believe that medical services in cases where a pregnancy is unwanted or medically undesirable should be available without undue legislative restrictions.
> *Mr. Hastings:* Would Medicaid payments cover abortion costs in a case where abortion is legal?
> *Mr. Richardson: "Yes, it would, where it is otherwise as you say a legal service."* Hearings on H.R. 4208 before the Subcom. on Pub. Health and Envir., Int. and For. Commerce Comm., House of Representatives, 91st Cong., 2nd Sess., Part I, at 99. (Emphasis added).

As is discussed above there is nothing in the choice

of the phrase "family planning" to indicate that Congress intended to exclude abortion services as an acceptable back-up method in a comprehensive family planning program under Title XIX. More importantly, there is no indication in 42 U.S.C. §1396d(a)(4)(C) that Congress intended to single out family planning services as exempt from Title XIX's general requirements.

Like any Title XIX medical assistance service, the extent to which a state may exclude particular methods of providing the service must, in large part, be determined with reference to the requirements of Title XIX as a whole and the statutory purpose for providing the service. *Burns v. Alcala, supra.*

Congress intended for all mandatory Title XIX services to be "sufficient in amount, duration and scope to reasonably achieve their purpose." 45 C.F.R. §249.10(a)(5)(i). Using this standard, if the purpose behind providing a particular service is broad, the ability of the state to exclude recognized services which promote the purpose is similarly broad. Thus, the broadness of a goal such as that which was inherent in the Congressional decision to require states to provide physician's services can be reasonably met despite the exclusion of certain services physicians generally provide, physical check-ups, cosmetic surgery, dental or eye care.

However, when the goal behind a particular service is more specifically delineated the result often is that the state's ability to exclude generally recognized ways of providing such services are necessarily restricted. For example, while a state need not provide eye care services so as to promote the access of indigents to physicians services, if the state elects to provide eyeglass services they must provide enough eyeglass services to assure that the purpose behind that specific service, "improving vision", will be met. Thus, one Court has

concluded that a state's refusal to provide eye care to persons with refractive error violates Title XIX because by doing so the state fails to provide enough services to reasonably assure the improvement of vision. *White v. Beal, supra.* The goal of family planning is similarly narrow. Moreover, the various generally recognized methods which enable persons to limit and/or space their children are few in number. Given the fact that many women cannot use contraception medications or devices, that all known methods of contraception have a certain failure rate, and that some women will invariably change their mind regarding childbirth after becoming pregnant, the state cannot claim that it is providing enough family planning techniques to reasonably assure that all indigent persons will be able to limit and/or space their children. No one would argue that abortion services should be the primary method of assuring that persons are given the ability to control their families growth. But, given the current state of contraceptive technology and level of knowledge among low-income persons concerning contraceptive practices, the exclusion of abortion as a family planning method frustrates to a large degree the ability of persons to control their family growth, without serving any other purpose.

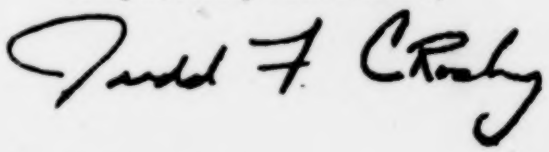
In addition to requiring that states provide enough of a given service to assure that the goal or goals behind such a service is met, Congress also intended that no state could arbitrarily deny or reduce the amount, scope and duration of a service to an individual solely because of such person's physical condition. 45 C.F.R. §249.10(a)(5)(i). Yet, if family planning services does not include abortion services every woman who is pregnant at the time she seeks family planning services or whose prior services were insufficient to prevent conception is eliminated from coverage.

Absent some indication that Congress did not intend to require states to provide enough services to reasonably assure that all indigent persons would be able to limit and/or space their children and intended to totally deny coverage to an entire class of recipients a state may not, consistent with Title XIX, refuse to provide abortion services to those Title XIX eligibles who after consultation with their physician seek an abortion.

CONCLUSION

On the basis of the above authorities and arguments, Respondents respectfully request this Court to affirm the decision of the United States Court of Appeals for the Third Circuit entered on July 21, 1975 by the court *en banc*, three of nine judges dissenting.

Respectfully submitted,



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